

S. No. 2
M-1-4-41
v. 5-17-35
I X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN - 5 1943 18
Registration District No. _____

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003
Primary Registration District No. _____

38507
State File No. 10676
Registrar's No. _____

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis - Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Bethesda Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days
(Specify whether _____)
In this community 24 yrs.
years, months or days)

3. (a) PRINT FULL NAME Emma Boova
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Anthony Boova
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased May 23 04
(Month) (Day) (Year)

8. AGE: Years 38 Months 6 Days 26
' If less than one day _____ hr. _____ min.

9. Birthplace Hawkrn. Penn
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Abraham Crockett

13. Birthplace England
(City, town, or county) (State or foreign country)

14. Maiden name Carolyn Dawson

15. Birthplace Penn
(City, town, or county) (State or foreign country)

16. (a) Informant Husband - Anthony Boova

(b) Address 4065 West Pine Blvd.

17. (a) Removal (b) Date thereof 12-19-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Glen Carbin, Ill.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 47009 Washington Blvd.

19. (a) _____ (b) J. F. Brudick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4065 West Pine Blvd.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 12 day 18
year 1942 hour 11:00 minute _____ P. M.
21. I hereby certify that I attended the deceased from Nov 1
1942 to Dec 18 1942
that I last saw her alive on Dec 18 1942
and that death occurred on the date and hour stated above.

Immediate cause of death: Septic Shock
Due to Tubal hysterectomy
Endometrial cyst Rt ovary
Post operative adhesions
Due to No malignancy
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations as above
Of autopsy Report
Duration _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature John W. Stewart (M. D. or other) _____
Address Lucas Bldg Date signed 12/19/42

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

10676
9290T

10676
9290T

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Julius G. Burnley

Licensed Embalmer No. *4302*

P. O. Address.....

St. Louis, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.